IMHA WORKING GROUP MEETING REPORT

Odessa, September 16-17, 2005

DRUG and ALCOHOL ABUSE AMONG SEAFARERS: the ROLE of the HEALTH PROFESSIONS

Venue meeting place: Hotel "Valentina", Odessa, Kurortny Lane 1

IMHA WORKING GROUP MEETING

With supporting funding from the ITF Seafarers' Trust

INDEX

1.- IMHA working group meeting programme

2.- Objectives and main points for discussion

3.- List of participants

4.- Summary and main conclusions.

5.- Budget and expenses

1.- IMHA working group meeting programme

PROGRAMME TIMETABLE

	September 16, Friday		
Moderator: Dani Appave (ILO)			
10.00-10.20		Tim Carter (UK)	Opening the meeting and welcoming the participants
10.20-11.30		Suresh Idnani (India)	Drug and alcohol prevention programme
11.30-11.50	**Coffee break**		
11.50-13.30		Dani Appave (ILO)	Leading discussion on the morning presentations
13.30-14.30	**Lunch**		
Moderator: Gregory Tchkonia (Georgia)			
14.30-15.10		Alexandr Panaiotov (Ukraine)	Narcological monitoring of seafarers in the Ukraine: the general approach to the problem
15.10-16.00		Gregory Tchkonia (Georgia)	Discussion
	September 17, Saturday		
Moderator: Tim Carter (UK)			
9.30-10.30		Gregory Tchkonia (Georgia)	Drug use aboard ships
10.30-11.00	**Coffee break**		
11.00-13.00		All participants	Discussion and conclusions

2.- Objectives and main points for discussion

1. To make recommendations to health professionals on their role in managing drug and alcohol policies and programmes in seafarers.

2. This should be in line with:

- **the international and national guidelines on prevention of drug and alcohol abuse**
- **good ethical standards of medical practice**

3. And should be informed by

- **available evidence**
- **clinical experience of working group members.**

4. Any significant gaps in knowledge should be identified.

Local organizing committee in Odessa:

- **Dr. Alexandr Panaiotov** - Director of Centre for Psychiatry and Narcology Ukrainian Research Institute of Maritime Medicine.
- **Natalia Efremenko –** Chief of Department Ukrainian Research Institute of Maritime Medicine.
- **Dr. Taissia Demidova –** Director of Centre for Maritime Medicine Ukrainian Institute of Medicine of Transport.

International organizing committee:

- **Dr. Gregory Tchkonia –** Chairperson, Deputy Director of Batumi (Georgia) Maritime Medical Centre.
- **Dani Appave –** Senior Maritime Specialist International Labour Office (ILO)

IMHA coordinator: Dr. Ülle Lahe (Estonia)

Evaluation final report: Dr. Tim Carter (UK), Dr. Gregory Tchkonia (Georgia)

Language for presentations and discussions: English

3.- List of participants

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4.- Summary and main conclusions

Rapporteur: Tim Carter

Note: this report builds on the International Labour Organization (ILO) manual 'Drug and alcohol abuse prevention programmes in the maritime industry'.[1] *It fills a gap in this document by addressing the role of the health professionals who play an important role in several aspects of any such programme. Topics discussed in the ILO manual and raised at this meeting without additional commentary have been omitted from this report.*

A. Introduction

There has been increased concern about drug and alcohol problems among seafarers in recent years. This relates both to the acute impairing effects and their consequences for vessel and personal safety and to long term damage leading to premature termination of careers at sea.

The meeting followed earlier discussions between Russian, Ukrainian and Georgian members of IMHA. These particularly related to the role of health professionals in drug and alcohol control programmes. Such involvement often leads to ethical problems from the conflicts between maritime safety, good clinical medical practice and the demands, especially of shipping agents servicing foreign flagged companies, for specific testing to be undertaken with any positive results leading to non-employment rather than to investigation and treatment.

The meeting started with three presentations about aspects of drug and alcohol abuse and its management in seafarers, followed by discussion sessions. Then a standard structure for programme management was used as the basis for defining the roles of health professionals at each stage. The overall emphasis was on sound problem definition, recognising that drug and alcohol misuse is in part nationally and culturally determined but with specific issues which influenced seafarers, and on the use of valid methods of intervention to control drug and alcohol problems.

It was agreed that, while there were three main types of impairing substance of relevance: alcohol, drugs which are usually illicit and used for their psycho-active effects and medications used primarily for therapy but sometimes having impairing side-effects, the latter should not be included in the discussion. Further work was needed on policies concerned with the use of medication by seafarers although there are some guidelines available or in preparation.[2]

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1 Drug and alcohol abuse prevention programmes in the maritime industry: a manual for planners - revised. International Labour Organization 2001. ISBN 92-2-112372.

2 UK Maritime and Coastguard Agency. Maritime Guidance Note on policies on the use of medications by seafarers – in press.

B. Presentations

1.Dr Idnani (India)

This overview indicated, from an historical perspective, the involvement of a wide range of international organisations, in drug and alcohol policies or in related matters, such as human rights or the medical examination of seafarers which laid the ground for such policies; notably the ILO as the body concerned with working conditions, and the International Maritime Organization (IMO) in respect of the maritime safety implications.

In the case of illicit drugs there are wider concerns about discouraging trafficking and the development of addiction. Here policies applied to seafarers and other workers could provide both personal deterrence and general deterrence. For alcohol the development of policies had been given impetus by the high cost (c.$2Bn) and damage to corporate image caused by the fuel spill from the Exxon Valdes in 1989.

Every individual has a right to privacy which must not be infringed by any imposed policy, the observed voiding or urine for testing can readily be seen as excessively intrusive. However the are usually legal rights which enable an employer to promulgate rules to operate an enterprise in an effective way, provided such rules are specified in advance, clearly communicated to all employees, with the consequences of non-compliance stated. Such rules have also been introduced by international organisations – IMO[3], state bodies – US Coastguard,[4] and by employers' associations – Intertanko, Oil Companies International Marine Forum (OCMF). Some of these also include provisions for rehabilitation, education and counselling. More broadly the ILO has produced the document noted above for planners. This is directed at the maritime aspects of drug and alcohol abuse prevention.[5]

Drug and alcohol abuse are not simply individual problems, they may be reactions to work stresses and insecurity, poor working conditions and the absence from home which is a feature of seafaring lives. As far as is practical these must be addressed before any programme can be effective.

Responsibilities for control rest in many places and effective co-ordination is needed, involving national maritime authorities, employers, ship masters and individual seafarers. Co-ordination is particularly difficult where recruitment and

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3 International Maritime Organization. STCW '95: Part 5 Guidance on Prevention of Drug and Alcohol Abuse. IMO: MSC/Circ. 595 – Principles and guidelines concerning drug and alcohol abuse programmes. MSC/Circ. 634 – Drug and alcohol abuse.

4 US Coastguard drug and alcohol rules. Summary www.uscg.mil/d5/safety/dapiweb/ Detail www.uscg/hq/g-m/moa/dapip.htm

5 See ref. 1

service is across national and cultural boundaries or where employment is short term and casual. It is here that the greatest ethical problems arise when employers only seek to reduce their short term risks and there is diffuse or absent responsibility for the long term health and welfare of seafarers.

2.Dr Tchkonia (Georgia)

Despite the apparent growth in drug use and recognition of the impairing effects of drugs and alcohol there are important uncertainties, which limit the development of rational policies for control. The duration of impairment for different agents and the interactions, both between substances and with other stressors such as fatigue are imperfectly understood. The determinants of which users become abusers are not well established, and the effectiveness of different interventions to prevent, treat or rehabilitate abusers is not known.
Patterns of drug and alcohol and abuse vary widely and are to an extent culturally determined.

Most organisations favoured the use of drug and alcohol screening techniques as a part of maritime programmes. There was however an alternative view that screening added little to other forms of intervention and had so many ethical and practical problems that it should only be introduced in a narrow range of situations.[6]

It is possible to identify the attributes of abusers using predictive psychological testing. In discussion it was clear that such testing was used quite extensively in the Ukraine. It was less clear how criteria were derived from test experience and applied to decisions on the fitness or need for surveillance for individual seafarers.

3.Dr Panaitov (Ukraine)

The formal promulgation of a drug and alcohol abuse prevention programme is not sufficient to ensure that effective preventative action is in place. For instance in Ukraine only pre-employment testing is undertaken and there is no follow-up of those testing positive, nor is there a national database of results. Hence someone with a problem can simply go to another clinic after a short period of abstinence and try again. There is a state system of narcology inspectors who may be called in to investigate incidents and accidents.
In Ukraine the majority of positive tests are for alcohol -8/10. This differs from the pattern reported from Georgia where drugs predominate. Drug positives are commonest in young age groups with alcohol in older ones.

C. General discussion

[6] Independent Inquiry on Drug Testing at Work, Drugscope report 2002. Funded Joseph Rowntree foundation (UK), Network of European Foundations.

1. Pre employment/voyage assessment

Much of the discussion focused on the use of chemical and other test methods to assess past present or future use. This was seen as the area where the most difficult ethical issues arose.

Most of those present considered that chemical testing for the presence of drugs and alcohol was a necessary part of pre-employment assessment and felt that this should be done as part of the medical examination process. A minority view that as these methods did not add useful predictive information on future risk and also posed ethical problems they should not be used by health professionals at this stage of employment gained little support. Testing was considered to be a reasonable part of the disciplines of employment in some countries, however a number of problems were noted.

- For all agents except cannabis, testing only reflected use in the last 1-2 days and so if abstention was possible for this long anyone could pass a test.

- It was well recognised that all the crew of what was clearly a ship with a pattern of heavy drinking could have tested negative prior to the voyage.

- Where crewing was international employers sometimes specified batteries of tests which did not reflect drug use in the seafarer's home country and this could impose high costs if irrelevant tests were required and they not available locally.

- Seafarers were sometimes required to pay considerable sums for tests to be done at a time when they were not earning. Some employers covered the cost of tests, some refunded the costs to those seafarers who were employed (this was at times because of pressure from the examining clinics). Others considered that if a seafarer wanted a job they should pay the cost of clearance.

- In this situation it was easy for clinics to simply fulfil the requirements of employers and their agents on substance testing as well as on, for instance, hepatitis, HIV and pregnancy testing even when this is ethically dubious or even outside their national law.

- For casual or single contract crew members employers seem more concerned to cover themselves by having a negative certificate that with any aspect of the health or welfare of seafarers, especially when there is competition for jobs.

- By contrast few national maritime administrations require any form of routine testing, although they do place restrictions or prohibitions on seafarers who have clinically apparent or declared drug or alcohol abuse.

- Psychological tests are regularly used in some countries as a part of pre-employment narcological assessment, those with experience of these methods considered that they improved identification of those at risk of future substance abuse. problems. Methods included general test batteries to identify cognitive function and personality traits, supplemented by in-depth analyses of subjects' responses to depictions of faces or other patterns.

- Measurements of liver enzymes such as gamma GT and of red cell volume were also sometimes used to evaluate longer term effects of regular alcohol use.

- It was noted that some national administrations such as the Netherlands had sophisticated question sets in their pre employment questionnaires designed to ask about substance abuse from several perspectives, but this was not the norm and most statutory declarations simply asked either the recruit or the examining doctor to record information about fact and quantity of use.[7]

2. While employed/at sea.

In service aspects were less familiar ground to most participants as they were not predominantly the responsibility of health professionals. The following points were raised.

a) It was often impractical to provide education on substance abuse in the pre-employment setting because of the recruit's over-riding concern to obtain work. This could either be provided during a voyage or at a post voyage medical, when one was performed.

b) The culture of the ship, both in relation to substance abuse and more generally in terms of whether it had an ethos which favoured crew health and welfare could play a big part in determining the patterns of drug and alcohol

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7 The question set used in NL is based on the CAGE questionnaire. (Ewing J, University of North Carolina, USA)
Do you drink alcohol. If so how many drinks per day?
Have you ever felt that you should cut down your drinking?
Have people annoyed you by criticising your drinking?
Have you ever felt bad or guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Do you smoke? If so, how much per day?
Did you use narcotics or stimulants in the past five years?

use. Sanctions in the event of improper use could act as re-enforcers, while misuse by the master and senior officers could have a negative effect.

c) Some employers ran alcohol free ships, others had access limited by type, time or volume. Some allowed, colluded with or even profited from unrestricted access. A degree of control was seen as essential but a 'dry' ship was seen as impractical in some national cultures and could possibly lead to hidden drinking.

d) The illegality of most non-therapeutic drug use necessarily made any finding of the presence of drugs on board a matter of serious concern for the master and owners.

e) Most on-board testing was because of company policies rather than statutory requirements. Options included random testing, usually immediately on arrival in a port but occasionally at sea on larger vessels. Some ships carry dip-stick drug detection kits and these may be used on suspicion or for cause after an incident. Alcohol use can be measured by breath testing and this may be on suspicion or for cause using a disposable breathalyser, or on a regular basis prior to watch-keeping using an electronic detector. STCW includes a limit of 0.08% for watch keepers.[8] It was suggested that this sent the wrong message to non-watchkeeping crew members. The finding of a positive test on a leanly manned ship during a voyage can pose difficult decisions for a master who has to decide what action to take. Only a few national authorities have requirements for on board testing, this is normally done as a forensic investigation after an incident.[9]

f) Alternative control methods include a requirement for an alcohol free pre-duty period (4 hours specified for watch-keepers in STCW). A fit for duty log may have be signed as the start of each watch or a signed declaration that certain norms will be followed throughout a tour of duty may be used. Observation of crew members' performance and behaviour by officers remained an important way of identifying problems.

d) Case management

The clinical response to those with drug and alcohol problems depended very much on the conditions of employment of seafarers. Where this was permanent and the problem was recognised without becoming a disciplinary matter some employers provided treatment and rehabilitation as a part of comprehensive health care plans or as the positive part of a substance abuse programme which rewarded self-declaration by supporting access to treatment. This was not the case with casual or short-term contract seafarers, who were screened out and rejected prior to employment or dismissed and sometimes black-listed if a

8 See ref. 3.

9 Railway and Transport Safety Act 2003. Part 4 Section 78.

problem became apparent while working. Continuity of medical records and the use of the same maritime health clinic for all contacts could assist with the response to early or uncertain cases of abuse, provided that the clinic was acting solely in pursuit of maritime health and safety and the seafarer's interest. If a clinic was obliged to act in a discriminatory way on behalf of an employer this would be undermined.

Some states provided either specialised services for seafarers or, where social security systems were advanced, handled seafarers within the public health-care system. A number of NGOs also provided therapeutic and support services. Some, such as Alcoholics Anonymous, were international and could provide support for mobile workers. Port health clinics and welfare services could play an important role as routes of access. There is little sound evidence indicating which forms of therapy are most effective at returning seafarers to their career or of whether high cost psychotherapeutic approaches are more effective that lower cost alternatives.

Confidentiality aspects of the transfer of information between different services, especially when there was doubt about whose interest they were acting in, could be barriers to efficient case management.

Denial of a personal problem with abuse and resistance to treatment were common. This could lead to non-disclosure to medical assessors and to manipulative 'shopping around' for a clinic which would not identify abuse and then prevent employment.

e) The wider context

As substance abuse was a wider social matter and not just a seafarer problem it had to be seen in this context. If there was no information on the scale and severity of problems nationally or by sector of employment it was impossible to plan sound policies for seafarers. Attitudes were first formed by family, contacts and schools and later could only be modified, for instance during maritime training and cadetship. Hence substance abuse had to be included in course content at all levels and then knowledge assessed. In parallel social attitudes which stigmatised it as a self-inflicted condition could be very unhelpful to the handling of those with the problem, especially if they were reinforced by an insurance system which did not pay for treatment for such problems.

Some countries had systems those who where addicted to drugs or alcohol were registered. Being on a register could give some entitlement to treatment. It could also be a source of information when credentials were being checked prior to employment. It did however stigmatise a group and place them is a restricted and dependent role.

Similarly wider social attitudes to health promotion and to the role of lifestyle as a major contributor to disease in later life may influence how substance abuse is prevented and responded to. As the working life of seafarers is so different from that of other members of society, with their on duty work and life segregated from periods of leave and only under personal control in limited ways, special health promotion programmes are likely to be needed. With multi-national crewing programmes may not always reflect local values. A policy on drug and alcohol use on board a ship will provide a clear focus for educational initiatives. These are most likely to be supported if they are jointly negotiated between seafarers' representatives and those of maritime employers and they need to be understood prior to a voyage.

D. The health professional's contribution

1. Ethics and practice

The role of the doctor or other health professional in the management of substance abuse in seafarers can be complex and pose ethical conflicts and uncertainties. This is because of the many different parties involved and their interests which while all concerned to prevent problems have differing approaches and priorities. The contribution of most other parties to drug and alcohol programmes has been considered in earlier documents, but not that of the health professional.

The health professional may be involved at any stage of the development, implementation and evaluation of a programme for the management of such abuse and this is analysed later. They may help with planning, be used to undertake particular tasks such as screening or act in a more traditional capacity in the identification and treatment of cases. They may be asked to produce an evidence-based rationale for approaches which are wanted for political or operational reasons but which are not properly validated. They may themselves be an interested party that is gaining income or status from their part in a control programme. In all of these roles they remain health professionals bound by codes of ethics and liable to criticism or de-registration if they do not comply with their codes. Tasks include.

a) Advisor on policy to international organisation, state maritime or health authority, ship owner/employer or related body such as P and I club or crewing company, trade union, NGO.

b) State approved assessor of fitness working to national legal standards.

c) Assessor acting for employer or related body working to non-statutory standards, often overlaid on flag state ones. This may be for a home-state employer with home-state crew, for a home-state employer engaging non home-state crew or for an employer from another state engaging crew from

their home-stat. Requirements may also depend on the flag of a ship. Where a crewing agent is the initiator of the request for assessment they may sometimes not know the destination of the seafarer being recruited.

d) Assessing an incident or a seafarer who is suspected of having a problem. This may sometimes include being the supervising medical officer to a drug and alcohol screening programme.

e) Giving clinical advice to a seafarer with a problem of abuse and managing their investigation, treatment and rehabilitation for possible return to work as a seafarer.

The employment status of the health professional can be as a formal employee of the organisation using their services, as a member of a health clinic or academic department or as an independent contractor. Payment may be by salary, on a term contract basis or fee for item of service. Thus reward and continuity of income can be used to secure adherence to the interests of one of the parties requiring advice, sometimes with adverse effects on others.

The prime defence of the health professional's position in this complex web is openness and clarity to all and especially to seafarers, on whose interest is being served and on what the consequences of any adverse findings are; for instance, by ensuring that seafarers have been made aware of the drug and alcohol policies operated by their employers before the health professional makes any assessment which forms a part of the policy. They should also reserve the right to cease to undertake work for any organisation that has policies which they do not consider are operated in the interests of safe and sound maritime operations or the preservation of the health of seafarers.

The second defence is ensuring that all methods for assessment and intervention which are used are scientifically validated and performed to a standard which complies with norms of good professional practice; for instance by only using laboratories which are taking part in quality assurance schemes. Unproven techniques should only be accepted as part of a soundly based research programme.

The health professional will normally be acting as an advisor rather than an executive, except regarding treatment of individual seafarers. Advice may be presented with or without commentary; an example of this being the provision of drug and alcohol test results to an employer as a list of positives or negatives, leaving the interpretation of the results to the employer, who should have had prior scientific advice on their significance in general terms and on the safeguards needed to avoid false positives. Any advice about an individual which may be disputed should be provided in writing so that if there is later contest the element of professional opinion in a decision remains clear and cannot be misrepresented.

A particular problem arises when a seafarer meets flag state medical fitness standards, which rarely specify drug and alcohol testing but does not meet those of an employer. Here it is the duty of the health professional to provide the seafarer with the flag state certificate, as required in international law and to tell them that it is the employer's policy which has led to any decision on fitness. Thus, where available, the seafarer could use legal remedies to challenge the potential employer's decision.

2) Policy development and implementation

A health professional with relevant experience and expertise is an essential member of any team developing policies, whether at international, national or local/company level. The following aspects may require their advice.

- The scope of policies; should drugs, alcohol and medication be handled together or separately?

- Current knowledge on the incidence and prevalence of problems. Are they sufficiently frequent to justify policy development or to shape the policy?

- The nature and time course of impairment caused by different substances and the likelihood of continuing dependence/addiction. The consequences of impairment for safety and health and of dependency for continuing disruption and spread of use to other crew members.

- The place of the health professional in any control programme, the ethical and practical aspects and how to resource such skill requirement and make providers accountable for service delivery.

- The validity of different forms of action. In particular the options for and place of clinical assessment, chemical testing and support for those with problems. The interpretation of results of any testing.

- Information for seafarers about substance abuse policies. The use of health education and promotional techniques and whether substances should be handled separately from other lifestyle issues.

- The implications of any programme for the seafarer and other bodies: needs for clinical services, social security and health insurance aspects, termination of career, loss of skills to the industry. How can any unmet needs be resolved; for instance if care is offered if a problem is declared rather than found who will fund the care?

- How ship masters and senior officers should be included in programmes, when they have executive functions, set the culture of a vessel but may themselves have problems of abuse, which if present are more likely to put the ship in danger than similar problems in other crew members?

3) Primary prevention

Most aspects of primary prevention do not fall to the health professional but they are well placed to advise on some.

a) How should substance abuse be presented? To what extent is it a personal behavioural matter and to what extent is it an illness? Advice on this is likely to be closely bound to the health belief systems of the seafarer. How the role of the health professional and of any testing regime is presented to seafarers

b) To what extent can the working and living environment on board be modified to reduce problems. Access to alcohol on the ship. Sale from ships bond, price charged and who profits? Rules on personal supplies. Work stresses and the reduction in use of alcohol or drugs as a coping behaviour, shore leave and sanctions on returning to ship impaired.

c) What effect is the use of casual or short term contract crew rather than permanent employees likely to have on patterns of substance abuse and on the costs and effectiveness of preventative measures?

4) Individual assessment, testing and case recognition

Health professionals are intimately involved in these aspects of a policy. Problems may be identified as a result of pre-employment or periodic clinical assessments or between times either because of random testing or following an incident.

- The methods used may be decided by the professional or be specified by the employer. Ethical aspects are noted above. The validity of any methods selected by the health professional is their responsibility. They should also have a well informed view on assessment methods required by others and on their validity and acceptability.

- The limited role of pre arranged testing at a pre employment assessment is discussed above and all those requiring it should be advised of these limitations.

- The place of psychological screening needs to be considered, including the dangers of stereotyping individuals based on deviations from average values when tests are used in a competitive and casual employment market.

- Case management arrangements need to be put in place so that a person found to have a problem can be readily referred for treatment.

5. Clinical management

This aspect is in many ways the simplest for health professionals as it is aligned with the approaches used in other areas of clinical practice and their position is established and seen as definitive by others.

a) The clinical follow up on those where there is suspicion of a problem needs definition. What is the place of further testing, for instance of liver function and for macrocytosis with alcohol, and for psychological assessment.

b) Referral arrangements: to primary care; to specialist treatment and rehabilitation; to voluntary bodies such as Alcoholics' Anonymous.

c) Are specialist services available and who pays for them? Should they be specific to seafarers?

d) Who is responsible for decisions on fitness to return to seafaring after completion of treatment and rehabilitation?

e) How should a person who denies that they have a drug or alcohol problem, despite being diagnosed as having one be handled?

6. Programme evaluation

Like programme development this is an activity which involves several parties who will vary depending on whether a programme is national, company or local in conception. As most of the problem cases will have come to the attention of a health professional they are a major source of information when programmes are evaluated.

a) The meaning of 'success' and the criteria by which it is to be judged need to be specified. These are likely to differ for seafarers, the state, employers and health professionals and this must be resolved before evaluation is planned.

b) Primary measures include:
drug and alcohol related incidents and accidents
termination of career either from illnesses which are a consequence of drug and alcohol use or which result from the identification of use/misuse or of early disease.

c) Secondary measures:
assessments done and results
tests done and results

treatments given and results
educational initiatives and results

d) Tertiary measures:
skills and competencies of staff
acceptance of programme by all parties
costs and economic benefits

E. Knowledge gaps

In the course of the meeting a number of important gaps in knowledge and research needs were identified. Providing information to answer the following questions would enable the health professional to play their part in developing drug and alcohol programmes which are more effective, less discriminatory and lower in cost that those at present being followed.

1. The nature and extent of risk

a) What is the incidence of drug and alcohol misuse and their consequences in terms of disability in different countries and among different age, sex and occupational groups?

b) What is the pattern and frequency of progression from use to misuse/dependency for different agents? Can those at high risk of progression be identified?

2. Screening and diagnosis

- How well do pre employment, random and for-cause positive test results identify those with longer term problems or with a risk of repeated impairment?

- How much to various screening tests add to the clinical diagnosis of a persisting drug or alcohol problem?

- To what extent can psychological testing identify those at risk of drug and alcohol problems and can it identify from among those who test positive low and high risk groups in terms of recurrence or progression?

3. Effectiveness of intervention

- What is the contribution of the various facets of a programme to its effectiveness, and specifically are screening methods and involvement of health professions justified and beneficial?

- What is the frequency and timing of recovery after various forms of clinical intervention and rehabilitation? Can those most likely to benefit be identified?

F. Conclusions

This report does not lay down a specific set of actions required from health professionals in drug and alcohol programmes for seafarers. This is because their contribution depends on the nature of the programme and the position of the health professional in relation to it. The whole report and in particular section D does provide a set of questions and criteria to be used both by programme developers and by health professionals in ensuring that the programme and the health professional can interact effectively to ensure that problems arising from drug and alcohol use, misuse and dependence in seafarers can be minimised.

Programmes have come a long way in the last decade better use of health professionals could further improve them.

The old model:

What shall we do with the drunken sailor early in the morning?

Put him in the scuppers with the hose pipe on him early in the morning.[10]

The new:

Healthy seafarers, decent working conditions

Safe ships, clean seas.

5.- Budget and expenses

BUDGET IMHA WORKING GROUP MEETING		
Odessa (Ukraine) 16-17 September, 2005		
Type of expense	**Description of support**	**EUR**
Hotel and meal expenses of participants	Accommodation, coffebreaks, lunches, dinners	**1136,57**
Travel expenses of chairperson (Gregory Tchkonia)		**414,83**
Travel expenses of IMHA coordinator (Ülle Lahe)		**640.65**
	TOTAL ACTUAL:	**2192.05**

[10] Traditional British sea song.